

County _____

FORM B

Check here if this is a revised or an amended report. /___/

COMPREHENSIVE DRUG COURT IMPLEMENTATION**MAINTENANCE OF EFFORT (MOE)
AND MATCH EXPENDITURES QUARTERLY REPORT**

Project Budget Period: From: ___/___/___ To: ___/___/___ Billing Period: From: ___/___/___ To: ___/___/___

BUDGET LINE ITEMS	A	B
	Match Expenditures	Treatment Expenditures Affecting State MOE
Personnel	\$ -	\$ -
Fringe Benefits	\$ -	\$ -
Travel	\$ -	\$ -
Training	\$ -	\$ -
Supplies	\$ -	\$ -
Contractual Services	\$ -	\$ -
Indirect Costs	\$ -	\$ -
GRAND TOTAL	\$ -	\$ -

I hereby certify that all costs are consistent with the grant award.

X

Date: ___/___/___

Alcohol and Drug Program Administrator (AOD)

Please print name of AOD

Please use blue ink for original signature.